CRIME VICTIMS REPARATIONS BOARD

APPLICATION FOR MEDICAL PROVIDERS OF SERVICES

FOR VICTIMS OF SEXUALLY-ORIENTED CRIMINAL OFFENSES

Please note the following when sending in applications to the CVR Office:

1) **The 2-page application for Crime Victims Reparations assistance must be completely filled out and signed by an authorized representative of the health provider. It MUST be accompanied by a completed and signed Claim Form for Medical Expenses, a Medical Expense Verification Form and an itemized invoice for services performed.**
2) **Only one victim and one claimant is allowed per application form and a new application form must be submitted for each sexually-oriented criminal offense.**
3) **Please do not send an application to CVR unless it is complete.**
4) **Please send all paperwork on letter-sized paper. Please reduce larger documents and tape smaller documents to letter-sized paper.**
5) **Please do not use staples – please use paper clips instead.**
6) **CVR forms can be downloaded on the CVR website at www.lcle.la.gov/cvr.**
7) **Please submit all original applications, original claim forms, original medical expense verification form and original invoices to the following address:**

Louisiana Commission on Law Enforcement
Crime Victims Reparations Office
P.O. Box 3133
Baton Rouge, LA 70821

CRIME VICTIMS REPARATIONS BOARD
APPLICATION FOR MEDICAL PROVIDERS OF SERVICES
FOR VICTIMS OF SEXUALLY-ORIENTED CRIMINAL OFFENSES

Office: (225) 342-1749 Nationwide Toll-Free (888) 6-VICTIM www.lcle.la.gov/cvr

THIS BOX IS TO BE COMPLETED BY THE CVR OFFICE

Date Application Received _____ **CVR #**_____

In order for this application to be processed, you must complete all information on this application. ***PLEASE PRINT!***
You have one year from the date of the crime to file this application.

CLAIMANT INFORMATION

Provider Name:_____
(Hospital, Clinic, etc.)

Mailing Address: _____
Street Address or P.O. Box # City State Zip

Contact Name: _____
First and Last Name

Work Phone: ( )_____ Fax: ( )_____

E-mail Address:_____ Job Title:_____

VICTIM INFORMATION

Name _____ Social Security # _____
First, Middle, Maiden (If applicable) and Last

Address _____ City _____

State _____ Zip Code _____ Date of Birth _____

Home Phone ( ) _____Work Phone ( ) _____ Cell Phone ( )_____

SEX	VICTIM'S AGE **When Crime Occurred**	**ETHNIC BACKGROUND**:	Did **VICTIM** have a **disability** BEFORE the date of the crime?
☐ MALE ☐ FEMALE	_____	☐ Black ☐ American Indian ☐ Asian ☐ White ☐ Hispanic ☐ Alaskan Native	____ Yes _____ No

ASSIGNMENT OF RIGHTS

I hereby assign my rights for reimbursement of medical expenses related to this incident to:

Name of Hospital/Health Care Provider **Contact Person**

Provider Address (including City, State, Zip)

Victim's Account Number **Victim/Claimant Signature** **Date**

CRIME INFORMATION

Location of Crime (**Street, City, State, Parish**)

Date of Crime:

Briefly Describe Crime and Injuries: **(Please do not type or write "See Attached.")**

FORENSIC MEDICAL EXAMINER INFORMATION

Name of Examiner (Please print.)

Date Exam Performed:

INSURANCE COVERAGE

Use of private insurance in sexual assault cases **is voluntary,** and **not** necessary in order to receive assistance from the Crime Victims Reparations Board. If the victim chose to file with his/her insurance, please fill in the information requested below. If the victim chose not to use his/her insurance, or if the victim had no insurance, please check "None."

[ ] None [ ] Medical [ ] Medicaid/Medicare

Insurance Company Name _____

Policy # _____ Phone # _____

AGREEMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize and request any person having information, confidential or otherwise, necessary to the administration of my application and claims, to release that information to the Crime Victims Reparations Board.

This release includes, but is not limited to: physicians, hospitals, medical or mental health service providers. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original.

I understand that willfully and knowingly providing false information could result in a fine or imprisonment.

I certify subject to penalty of law that all information submitted with this application is correct and true to the best of my knowledge and that losses to be claimed are a direct result of the crime.

CLAIMANT'S SIGNATURE: _____ **DATE**: _____

PLEASE PRINT NAME: _____

TO THE SERVICE PROVIDER:

Please mail the completed application to:

Louisiana Commission on Law Enforcement
Crime Victims Reparations
P.O. Box 3133
Baton Rouge, LA 70821

Revised 8/6/15